STATE OF CALIFORNIA

VERIFICATION OF LICENSE/REGISTRATION/ CERTIFICATION IN ANOTHER STATE

ND-103 (New 11/04)

State of California Department of Consumer Affairs

Bureau of Naturopathic Medicine
1625 North Market Blvd., Suite S-209, Sacramento, CA 95834
Telephone: (916) 574-7991
Website: www.naturopathic.ca.gov

Applicant: Please complete (type or neatly print) Section I and mail one form to each state agency or board where you are now or have ever received a license, registration, or certification to practice medicine or healing arts. Please make as many copies as needed.

SECTION I – To be completed by the applicant

I am applying for a Naturopathic Doctor license in the State of California. The California Department of Consumer Affairs, Bureau of Naturopathic Medicine requests that your state agency or board complete Section II of this form as part of my application for licensure. By signing this form, I give my consent to release all and any information, favorable or otherwise, to the Bureau of Naturopathic Medicine. Please forward the completed form as soon as possible to the Bureau or Naturopathic Medicine at the address listed.

Applicant's Full Name: _____

My license, Reg, Cert. No. _____ was issued by your agency on _____.

X_____ _____
Signature of applicant Date Address

_____ _____
Print Name City, State, Zip

SECTION II – To be completed by the State licensing agency or board

1. The above individual is ☐ licensed ☐ registered ☐ certified as a (title) _____ in the State of _____

2. The name of the licensee/registrant/certified individual, as shown in our records:
_____

3. The license/registration/certificate is: ☐ current ☐ temporary ☐ suspended ☐ expired ☐ revoked
Issue date: _____ Expiration date: _____

4. Is this license in good standing? ☐ Yes ☐ No (If NO, indicate reason) _____

5. Are there any past or pending disciplinary actions (including informal or confidential discipline, consent orders, or letters of warning) against the licensee? ☐ Yes ☐ No (If Yes, attach an explanation).

6. At the time of licensure/registration/certification this individual met the following requirements:

Required Education: Degree _____

Regional accreditation required? ☐ Yes ☐ No

Reciprocity? ☐ Yes ☐ No. If yes, what jurisdiction? _____

Other: _____

Required Examination: ☐ Yes ☐ No. If yes, list examination(s), type, and title, and attach official examination results:

X_____ _____
Signature of Person Completing Form Date

_____
Printed or Typed Name and Official Title

(Affix State Agency/Board Seal in the below space)

_____
Agency/Organization Name

_____
Address

_____
City, State, Zip

Contact Telephone Number: _____

Return form to: California Department of Consumer Affairs, Bureau of Naturopathic Medicine
1625 North Market Blvd., Suite S-209, Sacramento, CA 95834